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BalanceWear®
www.BalanceWear.com

Phone: (888) 330-2289,
(510) 978-4198
Fax: (510) 254-3315
Email: Cindy@motiontherapeutics.com

Name: _____ Date: _____
Diagnosis: _____
Address: _____ DOB: _____
Phone Number: _____

Please check as indicated:

- ☐ Examination and treatment
- ☐ To support weak spinal muscles
- ☐ To reduce pain by restricting mobility of the trunk
- ☐ To support deformed spine
- ☐ To facilitate healing post soft tissue or spine injury
- ☐ To facilitate healing post surgical procedure on spine or related soft tissue
- ☐ Balance

ICD-10 code: _____
Signature: _____
Print Name: _____ *Print Title*: _____ *Date*: _____
NPI No. _____

************ Below area for therapist completion ************

- ☐ OW200 BalanceWear® Custom LSO
- ☐ BW300 BalanceWear® Classic
- ☐ BW350 BalanceWear® LightWeight™
- ☐ BW450 BalanceWear® Breeze™
- ☐ OW226 BalanceWear® Lumbar Support 6
- ☐ OW228 BalanceWear® Lumbar Support 8
- ☐ BW430 BalanceWear® Baseball Cap

No. Weights Needed:

1/2 lb. _____
1/4 lb. _____
1/8 lb. _____
1/16 lb. _____

Patient Measurements:
Waist: _____
Height: Front: _____ Back: _____
Cap:Adult _____ Youth _____

Measure
Waist: measure around waist at thickest part
Height Front: measure from top of shoulder down body to bottom front of vest.
Height Back: measure from top of shoulder down body to bottom back of vest.

Referring Therapist (Please print name): _____
Phone Number: _____

V: 7-8-18